THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-5896.M5

MDR Tracking Number: M5-04-0140-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 09-10-03.

The IRO reviewed aquatic therapy, therapeutic exercises, office consultation, vasopneumatic device therapy, electrical stimulation, hot and cold pack therapy and myofascial release rendered from 09-10-02 through 11-14-02 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-02-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
10/14/02	E0745-P	$495.00 (1 unit)	$150.00	M	DOP	96 MFG DME GR VIII	Requestor submitted documentation to meet DOP criteria. Additional reimbursement recommended in the amount of $495.00 minus payment of $150.00 = $345.00
10/22/02	97110	$35.00 (1 unit)	$0.00	F	$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
11/14/02	99243	$120.00 (1 unit)	$0.00	N,F	$116.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of $116.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
11/14/02	E0745-R	$200.00	$0.00	A	DOP	Rule 134.600	A- Denied for preauthorization. Pre-authorization was required per Rule 134.600 for DME in excess of $500.00 per item or cumulative rental. Services were in excess of $500 for the cumulative rental of the neuromuscular stimulator. Reimbursement not recommended.
TOTAL		$850.00	$150.00				The requestor is entitled to reimbursement in the amount of $461.00

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

This Decision is hereby issued this 12th day of April 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 09-10-02 through 11-14-02 in this dispute.

This Order is hereby issued this 12th day of April 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

December 31, 2003

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED DECISION
Corrected dates of service.

Re: MDR #: M5-04-0140-01
IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:
This male claimant injured his low back, resulting in right radicular leg pain, in a work-related accident on ___. On 04/01/02, he underwent a laminectomy to L4-L5 and was released by his surgeon to begin rehab on 09/04/02. Prior to this date, no rehab or therapy had evidently been performed.

The records provided for review show that he received approximately eight weeks of rehab with a re-evaluation performed at four weeks, and then again at eight weeks. This evaluation showed objective proof of improvement, but he was not at MMI at that point. Therefore, rehab continued until 11/14/02.

Disputed Services:
Aquatic therapy, therapeutic exercises, office consultation, vasopneumatic device therapy, electrical stimulation, hot and cold packs, and myofascial release during the period of 09/10/02 through 11/14/02.

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatments and services in dispute as stated above were medically necessary in this case.

Rationale:
According to the *Spinal Treatment Guidelines* and the *Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters*, this case would be classified as a sub-acute phase of care, which typically lasts approximately eight weeks following the acute phase of care. The *Spinal Treatment Guidelines* further categorize the patient into the secondary level of care because he is postoperative.

Clear documentation is provided of short- and long-term goals as noted by the treating doctor, and the appropriateness of the care provided. These are consistent with the aforementioned references, indicating that the treatment in dispute was medically necessary and reasonable.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,